

Mental Retardation Community Medicaid Services

INDIVIDUAL SERVICE PLAN

CRISIS STABILIZATION

____ Code # Clinical/Behavior Intervention ____ Code # Crisis Supervision

Individual: _____ Medicaid Number: _____

Provider Name: _____ Provider Number: _____

Start Date: _____ End Date: _____

Responsible Staff (name or position of implementer of the plan): _____

Number of **authorized** Crisis Stabilization days year to date: ____ (Maximum: 15 days per authorization/60 days per calendar year)

Goals/objectives are based on up-to-date assessment information present in the file.

CSP SELECTED GOAL/ DESIRED OUTCOME: *To provide direct interventions during a crisis to enable _____ to remain in the community setting.*

OBJECTIVES	ACTIVITIES/STRATEGIES	PROJECTED HOURS

Individual: _____ Service: **Crisis Stabilization** Start Date: _____ End Date: _____

CSP SELECTED GOAL/ DESIRED OUTCOME:

OBJECTIVES	ACTIVITIES/STRATEGIES	PROJECTED HOURS

**Attach a signature page that includes, at a minimum, the signatures of the individual/legal guardian and the provider's responsible staff member.*

Individual: _____

Date: _____

TOTAL HOURS/ UNITS PER WEEK OF **CRISIS SUPERVISION**: _____

GENERAL SCHEDULE OF CRISIS SUPERVISION SERVICES

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

COMMENTS:

(Role of other agencies if plan a shared responsibility)

**Attach a signature page that includes, at a minimum, the signatures of the individual/legal guardian and the provider's responsible staff member.*